Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5007HIC	A. BUILDING _____ B. WING _____	C 08/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELE'S CARE HOME	944 SADDLE HORN DR HENDERSON, NV 89015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments Surveyor: 28264 This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility 8/12/09 - 8/21/09. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The census at the time of the survey was two. Two resident files were reviewed and three employee files were reviewed. Complaint #NV00022789 was substantiated. See Tag H017	H 000		
H 017	Director Duties-Protective Supervision NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 3. Ensure that the residents of the home: (b) Receive: (3) Protective supervision and adequate services to maintain and enhance their physical, mental and emotional well-being. This Regulation is not met as evidenced by: Surveyor: 28264 Based on record review, observation and	H 017		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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H 017	Continued From page 1 interview 8/12/09 through 8/21/09, the director failed to ensure that 1 of 2 residents received protective supervision (Resident #2). Findings include: Resident #2 had been living in the facility for approximately two months. The Public Guardian's (PG) office reported that on 8/12/09 at 9:01 AM, she received a phone call from Caregiver #2 who related that Resident #2 was missing from the facility. The caregiver reported to the PG that she last saw the resident at 4:00 AM, that the resident was fully dressed and was saying that she wanted to visit her friend. At 8:30 AM, the caregiver noticed the resident was not around for breakfast. Caregiver #2 told the PG that she called the local police while the Director, Caregiver #1, went to look for the Resident #2. In later interviews the Director reported he found evidence the resident left through a sliding glass door that led to the backyard and out the back gate. The Director stated the resident had not attempted to leave the facility before and the back gate was kept closed with a rope. The Director reported he started looking for the resident in the neighborhood. A homeowner reported his daughter found Resident #2 outside of his residence,the resident appeared confused so he invited her in and offered her some water. Resident #2 implied that she had been thrown out of the facility she was living in and the caregivers were mean to her. The homeowner stated the resident showed him a birthday card and envelope with the address of her friend. The homeowner reported he was familiar with the neighborhood, so he volunteered to drive	H 017		

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H 017	Continued From page 2 Resident #2 to the address. On arrival at the address, the friend of Resident #2 requested that the driver return her to the facility. The homeowner reported he drove the resident back to facility and arrived at approximately at 9:10 AM. He reported there were three police patrol cars outside the facility when he arrived. The homeowner also revealed that his house was approximately 1 1/2 miles from the facility. The Public Guardian reported she was called at 9:42 AM by Caregiver #1 to inform her that Resident #2 had been found. The Public Guardian indicated she could hear the police in the background during the call. During the surveyor's interviews on 8/14/09, the Director said Resident #2 was last seen by Caregiver #2 at 6:00 AM, was found missing at 6:30 AM, and that the police arrived at the facility at 7:00 AM. The Director's story was inconsistent with the information provided to the Public Guardian by Caregiver #1 on the day of the incident and by the homeowner. The facility failed to take precautions to prevent Resident #2 from leaving the facility.	H 017		